(ii) The applicant agrees to permanently decertify all beds in and close one of the two nursing facilities identified in its application in consideration of obtaining a waiver to permit capital component payments to the remaining nursing facility identified in the application.

(iii) Closing the nursing facility will not create an access to care problem for day-one MA eligible recipients in the nursing facility's primary service area.

(iv) One or more of the beds decertified as a result of the closing of the nursing facility is a premoratorium bed.

(v) The legal entity is willing and able to transfer all residents that are displaced by the closing of the nursing facility to the legal entity's remaining nursing facility, unless the residents choose and are able to be transferred elsewhere.

(vi) The remaining nursing facility has one or more existing post-moratorium beds.

(vii) The applicant agrees that, as a condition of both obtaining and receiving continuing payment pursuant to the waiver, the remaining nursing facility will achieve and maintain an MA occupancy rate equal to or greater than the county average MA occupancy rate or the combined average MA occupancy rate (over the past 3 years) of the closed nursing facility and the remaining nursing facility, whichever is higher.

(viii) The applicant agrees that, if the waiver is granted, it will notify the Department in writing at least 90 days prior to the sale, transfer or assignment of a 5% or more ownership interest, as defined in section 1124(a)(3) of the Social Security Act (42 U.S.C.A. § 1320a-3(a)(3)), in the remaining nursing facility.

(ix) The legal entity is not disqualified from receiving a waiver under subsection (e).

(x) The applicant agrees that the waiver is subject to revocation under the conditions specified in subsection (f).

(xi) The applicant agrees that the Bureau of Hearings and Appeals affords an adequate, and appropriate forum in which to resolve disputes and claims with respect to the remaining nursing facility's participation in, and payment under, the MA Program, including

claims or disputes arising under the applicant's provider agreement or addendum thereto, and that, in accordance with applicable provisions of 2 Pa.C.S. §§ 501-508 and 701-704 (relating to administrative agency law) and §§ 1101.84 and 1187.141 (relating to provider right of appeal; and missing facility's right to appeal and to a hearing), the applicant will litigate claims pertaining to its remaining facility exclusively in the Bureau of Hearings and Appeals, subject to its right to seek appellate judicial review.

(xii) The applicant agrees that it will not challenge the Department's denial of capital component payments to post-moratorium beds in the remaining nursing facility.

(xiii) The MA Program will experience overall cost savings if the waiver is granted.

(xiv) The proposal is otherwise in the best interests of the Department. In determining whether the proposal is in its best interests, the Department may consider the following:

(A) Whether the legal entity has demonstrated a commitment to serve MA recipients. In making this determination, the Department will consider the MA occupancy rate of all nursing facilities related by ownership or control to the legal entity.

(B) Whether the legal entity has demonstrated a commitment to provide and develop alternatives to nursing facility services, such as home and community-based services.

(C) Whether the legal entity is willing to refer all persons (including private pay applicants) who seek admission to the remaining nursing facility to the Department or an independent assessor for pre-admission screening, and to agree to admit only those persons who are determined by that screening to be clinically eligible for nursing facility care.

(D) Other information that the Department deems relevant.

(2) If the Department concludes that the criteria specified in paragraph (1) have been met, the Department will grant a waiver to permit capital component payments to the remaining nursing facility. Capital component payments made pursuant to the waiver shall be limited to the number of postmoratorium beds in the remaining nursing facility as of the date the

waiver is granted, or the number of premoratorium beds decertified as a result of the closure of the other nursing facility, whichever number is less.

(e) *Disqualification for past history of serious program deficiencies.* The Department will not grant a waiver of § 1187.113(a) if:

(1) The legal entity, any owner of the legal entity or the nursing facility is currently precluded from participating in the Medicare Program or any state Medicaid Program.

(2) The legal entity or any owner of the legal entity, owned, operated or managed a nursing facility at any time during the 3-year period prior to the date of the application and one of the following applies:

(i) The nursing facility was precluded from participating in the Medicare Program or any state Medicaid Program.

(ii) The nursing facility had its license to operate revoked or suspended.

(iii) The nursing facility was subject to the imposition of sanctions or remedies for residents' rights violations.

(iv) The nursing facility was subject to the imposition of remedies based on the failure to meet applicable Medicare and Medicaid Program participation requirements, and the nursing facility's deficiencies immediately jeopardized the health and safety of the nursing facility's residents; or the nursing facility was designated a poor performing nursing facility.

(f) *Waiver revocation.* The Department will revoke a waiver, recover any funds paid under the waiver, or take other actions as it deems appropriate if it determines that:

(1) The applicant failed to disclose information on its waiver application that would have rendered the legal entity or nursing facility ineligible to receive a waiver under subsections (d) and (e).

(2) The legal entity or nursing facility violate any one or more of the agreements in subsections (d)(1)(ii), (v) and (vii)-(xii).

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(g) *Policy regarding capital component payments to participating nursing facilities granted waivers under Chapter 1181.* Waivers of the moratorium regulations granted to nursing facilities under Chapter 1181 remain valid, subject to the same terms and conditions under which they were granted, under the successor regulation in § 1187.113(a).

(h) *Effectiveness of waivers granted under this section.* Waivers authorized under this section will remain valid only during the time period in which this section is in effect.

(i) *Definitions.* The following words and terms, when used in this section, have the following meanings, unless the content clearly indicate otherwise:

Applicant - A person with authority to bind the legal entity who submits a request to the Department to waive § 1187.113(a) to permit capital component payments to a nursing facility provider for postmoratorium beds.

Day-one MA eligible - An individual who meets one of the following conditions:

(i) Is or becomes eligible for MA within 60 days of the first day of the month of admission.

(ii) Will become eligible for MA upon conversion from payment under Medicare or a Medicare supplement policy, if applicable.

(iii) Is determined by the Department, or an independent assessor, based upon information available at the time of assessment, as likely to become eligible within 60 days of the first day of the month of admission or upon conversion to MA from payment under Medicare, or a Medicare supplement policy, if applicable.

Owner - A person having an ownership interest in a nursing facility enrolled in the MA Program, as defined in section 1124(a) of the Social Security Act.

Legal entity - A person authorized as the licensee by the Department of Health to operate a nursing facility that participates in the MA Program.

Person - An individual, corporation, partnership, organization, association, or a local governmental unit, authority or agency thereof.

Post-moratorium beds - Nursing facility beds that were built with an approved CON or letter of nonreviewability dated after August 31, 1982, or nursing facility beds built without an approved CON or letter of nonreviewability after December 18, 1996.

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Pre-moratorium beds - Nursing facility beds that were built under an approved CON or letter of non-reviewability dated on or before August 31, 1982 and for which the Department is making capital component payments.

Primary service area - The county in which the nursing facility is physically located. If the provider demonstrates to the Department's satisfaction that at least 75% of its residents originate from another geographic area, the Department will consider that geographic area to be the provider's primary service area.

§ 1187.114. Adjustments relating to sanctions and fines.

Nursing facility payments shall be withheld, offset, reduced or recouped as a result of sanctions and fines in accordance with Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

§ 1187.115. Adjustments relating to errors and corrections of nursing facility payments.

Nursing facility payments shall be withheld, offset, increased, reduced or recouped as a result of errors, fraud and abuse or appeals under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies) and § 1187.141 (relating to nursing facility's right to appeal and to a hearing).

§ 1187.116. County nursing facility supplementation payments.

County nursing facility supplementation payments are made according to a formula established by the Department to county nursing facilities, in which Medicaid funded resident days account for at least 80% of the facility's total resident days and the number of certified MA beds is greater than 270 beds. Payment of the county nursing facility supplementation payments is contingent upon the determination by the Department that there are sufficient State and Federal funds appropriated to make these supplementation payments.

SUBCHAPTER I. ENFORCEMENT OF COMPLIANCE FOR NURSING FACILITIES WITH DEFICIENCIES.

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SUBCHAPTER J. NURSING FACILITY RIGHT OF APPEAL

§ 1187.141. Nursing facility's right to appeal and to a hearing.

(a) A nursing facility has a right to appeal and have a hearing if the nursing facility does not agree with the Department's decision regarding:

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(1) The peer group prices established annually by the Department for the peer group in which the nursing facility is included. The nursing facility may appeal the peer group prices only as to the issue of whether the peer group prices were calculated in accordance with § 1187.96 (relating to price and rate setting computations).

(i) A nursing facility may not challenge the validity or accuracy of any adjustment (except as provided in § 1187.141(10)) or any desk or field audit findings relating to the database or total facility CMIs used by the Department in calculating the peer group prices as a basis for its appeal of the peer group prices.

(ii) If more than one nursing facility in a peer group appeals the peer group prices established by the Department, the Office of Hearings and Appeals may consolidate for hearing the appeals relating to each peer group.

(2) The findings issued by the Department in a desk or field audit of the nursing facility's MA-11 cost report.

(3) The Department's denial, nonrenewal or termination of the nursing facility's MA provider agreement.

(4) The MA CMI established quarterly by the Department for the facility.

(5) The Department's imposition of sanctions or fines on the nursing facility under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

(6) The total facility CMI established annually by the Department for the nursing facility.

(7) The rate established annually by the Department for the nursing facility for resident care cost, other resident related cost, administrative cost and capital cost.

(8) The quarterly adjustment made by the Department to the nursing facility's rate based upon the facility's MA CMI. The facility may appeal the quarterly rate adjustment only as to the issue of whether the quarterly rate adjustment was calculated correctly.

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(9) The disproportionate share incentive payment made annually by the Department to the nursing facility. A nursing facility may appeal its disproportionate share incentive payment only as to the issue of whether the Department used the correct number of MA days of care and the correct inflation factor in calculating the facility's payment.

(10) A retrospective gross adjustment made under § 1187.108 (relating to gross adjustments to nursing facility payments), for the peer group in which the nursing facility is included. The nursing facility may appeal the gross adjustment only as to the issue of whether the adjustment was calculated in accordance with a final administrative action or court order.

(i) A nursing facility may not challenge the validity or accuracy of the underlying action or order which resulted in the retrospective gross adjustment.

(ii) If more than one nursing facility in a peer group appeals a retrospective gross adjustment, the Office of Hearings and Appeals may consolidate for hearing the appeals relating to each peer group.

(b) A nursing facility appeal is subject to § 1101.84 (relating to provider right of appeal).

(c) A nursing facility's appeal shall be filed within the following time limits:

(1) A nursing facility's appeal of the peer group prices shall be filed within 30 days of the date on which the Department publishes the peer group price in the *Pennsylvania Bulletin*.

(2) A nursing facility's appeal of the decisions listed in subsection (a)(2)-(10) shall be filed within 30 days of the date of the Department's letter transmitting or notifying the facility of the decision.

(d) A nursing facility's appeal shall meet the following requirements:

(1) A nursing facility's appeal shall be in writing, shall identify the decision appealed and, in appeals involving decisions identified in subsection (a)(2)-(10), shall enclose a copy of the Department's letter transmitting or notifying the nursing facility of the decision.

(2) A nursing facility's appeal shall state in detail the reasons why the facility believes the decision is factually or legally erroneous and the specific issues that the facility will raise in its appeal, including issues relating to the validity of Department regulations. In addition, a nursing facility appeal of findings in a desk or field audit report shall identify the

specific findings that the facility believes are erroneous and the reasons why the findings are erroneous. Reasons and issues not stated in a nursing facility's appeal shall be deemed waived and will not be considered in the appeal or any subsequent related appeal, action or proceeding involving the same decision. Desk or field audit findings not identified in a nursing facility appeal will be deemed final and will not be subject to challenge in the appeal or any subsequent related appeal, action or proceeding involving the same desk or field audit.

(3) A nursing facility may amend its appeal in order to meet the requirements of paragraph (2). A nursing facility shall file its amended appeal within 90 days of the date of the decision appealed. An amended appeal shall be permitted only if the nursing facility's appeal was filed in accordance with the time limits set forth in subsection (c). No subsequent amendment of an appeal will be permitted except under § 1187.1(d) (relating to policy).

(e) An appeal or an amended appeal shall be mailed to the Executive Director, Office of Hearings and Appeals, Department of Public Welfare, Post Office Box 2675, Harrisburg, Pennsylvania 17105. The date of filing is the date of receipt of the appeal or amended appeal by the Office of Hearings and Appeals.

(f) The Department may reopen an audit or a prior year's audit if an appeal is filed.

SUBCHAPTER K. EXCEPTIONAL PAYMENT FOR NURSING FACILITY SERVICES

§ 1187.151. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Exceptional DME grant (grant) - Authorization permitting exceptional payments under specified terms to a nursing facility, in addition to the nursing facility's case-mix per diem rate, for nursing facility services that are provided to a specified resident and that involve the use of certain exceptional DME. The amount of the additional payment authorized by a grant is based upon the necessary, reasonable and prudent cost of the exceptional DME and the related services and items specified in the grant.

Resident - An MA eligible resident of a nursing facility enrolled in the MA Program who, in a request for an exceptional DME grant, is identified as needing exceptional DME.

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§ 1187.152. Additional reimbursement of nursing facility services related to exceptional DME.

(a) The necessary, reasonable and prudent costs incurred by a nursing facility related to the purchase or rental, and the use of DME in providing nursing facility services to residents are allowable costs and included in the calculation of the case-mix per diem rates subject to this chapter. Any costs incurred in excess of the costs identified in a grant are not allowable costs under this chapter.

(b) When a nursing facility provides nursing facility services involving exceptional DME to an MA eligible resident, the nursing facility may, in addition to the submission of invoices for payment based upon the nursing facility's case-mix per diem rate, seek authorization for additional payment by requesting a grant from the Department in accordance with § 1187.153(a) (relating to exceptional DME grants - process).

(c) The Department will issue a grant to a nursing facility if the Department determines that all of the following conditions are met:

(1) The nursing facility's request for the grant complies with all applicable Department instructions.

(2) The specified DME is medically necessary as defined in § 1101.21 (relating to definitions).

(3) The DME specified in the nursing facility's request is exceptional DME as defined in § 1187.2 (relating to definitions).

(4) The nursing facility's physical plant, equipment, staff, program and policies are sufficient to insure the safe, appropriate and effective use of the exceptional DME.

(5) The nursing facility certifies to the Department in writing, on a form designated by the Department, that it has read and understands the terms of the grant.

§ 1187.153. Exceptional DME grants -- process.

(a) *Requests for exceptional DME grants*

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(1) A nursing facility shall request a grant in writing on forms designated by the Department and completed in accordance with all applicable Department instructions. The request shall be accompanied by the necessary supporting documentation specified in the Department's instructions and submitted to the Department within 30 days from the date on which the nursing facility purchases or rents the DME for which the nursing facility is requesting the grant.

(2) The nursing facility shall provide copies of the nursing facility's request to the resident and the resident's authorized representative, if any, when the nursing facility submits the request to the Department.

(b) *Notification by the Department.* The Department will send written notice of the Department's decision to approve or deny a nursing facility's request for a grant to the nursing facility, the resident, and the resident's authorized representative, if any.

§ 1187.154. Exceptional DME grants -- general conditions and limitations.

(a) *Scope and effect of an exceptional DME grant.*

(1) A grant authorizes exceptional payments to a nursing facility in addition to the nursing facility's case-mix per diem payment rate for nursing facility services provided to the resident. The amount of the exceptional payments authorized by the grant is deemed to be the necessary, reasonable and prudent cost of the exceptional DME and the related services and items identified in the nursing facility's grant.

(2) A grant does not authorize exceptional payments for nursing facility services that are provided to MA residents other than the resident, nor does it limit costs that are, or must be, incurred by a nursing facility to provide services to any of the nursing facility's residents (including the resident) in accordance with applicable law and regulations.

(b) *Applicability of laws.* Nursing facility services provided by a nursing facility receiving a grant, including services paid by the grant, remain subject to applicable Federal and State laws and regulations, including the laws and regulations governing the MA Program.

(c) *Reporting of exceptional DME costs and grant payments.*

(1) The nursing facility shall report on the MA-11, the costs related to the acquisition of exceptional DME and related services and items paid by a grant. In identifying the nursing facility's allowable costs, the nursing facility shall adjust those reported costs to the necessary, reasonable and prudent cost amounts identified in the nursing facility's grant.

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